

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-016932**  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **245**

Primary Registration District No. **3047**

Registrar's No. **58**

**FILED APR 23 1963**

1. PLACE OF DEATH a. COUNTY <b>Newton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Newton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Neosho</b>		c. CITY OR TOWN <b>Neosho</b>	
Length of stay in lb <b>10 Min</b>		Inside Limits <b>Yes</b> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Sale Memorial Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>Route #. 2</b>	
Reside on Farm <b>Yes</b> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lonnie Dell Hutchings</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-29-1892</b>
9. AGE (last birthday) <b>70</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (City and state or country) <b>Protem Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Hance Hutchings</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Cobble</b>	
14. NAME OF HUSBAND OR WIFE <b>Elizabeth Hutchings</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Elizabeth Hutchings</b>		Address <b>Neosho, Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b></b> a.m. <b></b> p.m. <b></b>	Month, Day, Year <b>1960</b>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY <b>Newton</b> STATE <b>Missouri</b>
21. I attended the deceased from <b>1960</b> , to <b>4-17-63</b> and last saw him alive on <b>3-1-63</b> Death occurred at <b>6:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Hayden</b> (Deedee or title)		22b. ADDRESS <b>Neosho, Missouri</b>	22c. DATE SIGNED <b>4-19-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-19-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Belfast Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>7 Mi W, Neosho, Mo</b>
24. FUNERAL DIRECTOR <b>Clark Funeral Home</b>		25. DATE RECD. BY LOCAL REG. <b>4-19-63</b>	26. REGISTRAR'S SIGNATURE <b>Hayden</b>

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59	DATE AMENDED
1 <b>0735</b>	
2 <b>0730</b>	
3	
4 <b>0</b>	
5 <b>1</b>	
6	
7 <b>0</b>	
8 <b>2</b>	
9 <b>4201</b>	
10	
11	
12 <b>93-0</b>	
13 <b>6-0</b>	

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer \_\_\_\_\_

**Signed**

Licensed Embalmer No. 8056

**P. O. Address**

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.